COLORADO INDIGENT CARE PROGRAM

FISCAL YEAR 2006

MANUAL

SECTION III:

PROVIDER AUDIT

EFFECTIVE: JULY 1, 2005

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ARTICLE I. AUDIT OVERVIEW

Section 1.01 Provider Compliance Audit and Purpose

To meet its fiduciary responsibility, the Colorado Indigent Care Program (CICP) requires that participating providers submit a provider audit compliance statement to the CICP administration. The purpose of the provider audit is to furnish the CICP administration with a report that attests to provider compliance with specified provisions of the CICP contract, regulations and manual. The following guidelines provide a basis for conducting the provider audit.

Those providers that receive over $1,000,000 in reimbursement from the CICP must submit an audit performed by an independent auditor (see section 1.05 for a listing of providers). Those that receive under $1,000,000 in reimbursement from the CICP may perform an internal audit rather than an external audit. An internal audit should be conducted by the facility's auditor. If the facility does not have an auditor on staff, then personnel who do not directly determine client CICP eligibility or handle CICP billing records should be chosen.

Section 1.02 Definitions

- **Covered Services** - All medically necessary services that a provider customarily furnishes to patients and can lawfully offer to patients. These covered services include medical services furnished by participating physicians. The responsible physician must deem which covered services are medically necessary. The CICP does not reimburse providers for outpatient mental health benefits as a primary diagnosis, but does cover limited inpatient mental health services for a period of 30 days per calendar year per client.
- **Emergency Care** - Treatment for conditions of an acute, severe nature which are life, limb, or disability threats requiring immediate attention, where any delay in treatment would, in the judgment of the responsible physician, threaten life or loss of function of a patient or viable fetus, Section 26-15-103, C.R.S.
- **Client** - A person who meets the guidelines outlined in the Colorado Indigent Care Program Manual, which stipulates that the individual must have income and assets combined at or below 185% of the Federal Poverty Level (FPL).
- **Provider** - Any general hospital, birth center, or community health clinic licensed or certified by the Department of Public Health and Environment contracted with the CICP to provide medical services.
- **Non-Emergency Care** - Treatment for any conditions not included in the emergency care definition and any additional medical care for conditions the Department determines to be the most serious threat to the health of medically indigent persons.

Section 1.03 Provider Compliance Audit Statistics

The Eligibility and Billing sections of the audit should use a sampling of CICP client records to estimate the provider's overall compliance with the program's rules and regulations. The following describes the philosophy behind the sample size selection and the risk level used in these sections of the audit. The criteria were selected based on the client population of large providers.

1. The level of precision, sometime called sampling error, is the range that the true proportion of the population is estimated to be. The range is often expressed in percentage points (e.g., ±5%). The CICP administration has chosen a level of precision of ±20%. A provider may choose to increase the level of precision to ±10% by increasing the sample size from 25 to 100.

2. The confidence or risk level is based on the idea that when a population is repeatedly sampled, the average value of the attribute obtained by those samples is equal to the true population. In a normal distribution, approximately 95% of the sample values are within two standard deviations of the true population mean. The CICP administration has chosen the risk of 10% that the sample does not represent the true population mean. The provider may not change this requirement and must explain all non-compliance results outside the 10% error rate.

3. The degree of variability in the attributes being measured refers to the distribution of attributes in the population. The CICP administration has chosen the maximum variability of 50% in a population, which is a conservative sample size. The provider may not change this requirement.

Section 1.04 Records Retention and Availability

All records, documents, communications, and other materials (except for medical records of Program clients) related to Contractor's and any subcontractor's participation in the Program shall be the property of the State and maintained in a central location by the provider as custodian thereof on behalf of the State, and shall be accessible to the State for a period of five (5) state fiscal years after the expiration of each state fiscal year. A further retention period may be necessary to resolve any matter which is pending at the expiration of each five (5) state fiscal year period. If an audit by or on behalf of the federal and/or State government has begun, but is not completed at the end of the five (5) state fiscal year period, or if audit findings have not been resolved after the five (5) state fiscal year period, such materials shall be retained for six (6) months after the filing of the final audit report and response thereto.

In addition, the provider will keep the material associated with conducting this audit, such as the audit work papers, for a period of five (5) state fiscal years following the conclusion of the audit. This material must demonstrate that the audit was performed within the standards outlined in this section. This material will not be submitted to the CICP administration unless a direct request for the documentation is made.

Section 1.05 Types of Audit

There are two types of audits associated with the CICP.

1. **Provider Compliance Audit**: The Provider Compliance Audit is the focus of this section. The compliance audit is conducted in one of two ways: external or internal. The compliance audit is normally conducted as part of the regularly scheduled annual financial audit for each provider institution. The auditor may perform a separate indigent care audit to test for compliance.

    a. **External Audit:** If a provider received over $1,000,000 in reimbursement (based on FY 2005 reimbursement established April 2005) from CICP, an independent auditor must perform an annual audit and submit a formal audit statement of compliance to the CICP administration. The following providers are required by the CICP administration to submit an annual External Audit for FY 2006:

• Denver Health Medical Center	• Memorial Hospital, Colorado Springs
• Montrose Memorial Hospital	• Northern Colorado Medical Center
• Parkview Medical Center	• Peak Vista Community Health Centers
• Penrose-St. Francis Health Systems	• Poudre Valley Hospital
• St. Mary-Corwin Hospital	• St. Mary's Hospital
• The Children's Hospital	• University Hospital

    b. **Internal Audit**: If a provider received under $1,000,000 in reimbursement from CICP, the provider may elect to conduct the annual compliance audit internally, rather than an external audit. If the provider elects to perform an internal audit, the provider administrator must submit an internal audit statement following the same provider compliance audit guidelines as the External Audit. An internal audit should be conducted by the facility's auditor or compliance officer. If the facility does not have an auditor or compliance officer on staff, then the audit should be conducted by personnel who do not directly determine client CICP eligibility or handle CICP billing records. Any provider not listed as required to submit an External Audit for FY 2006 (see above) may elect to conduct the annual compliance audit internally.

2. **CICP Administrative Audit:** All providers are subject to an audit by the CICP administration or a designee representing the CICP administration. This audit will examine the provider's eligibility and billing records. The CICP administration will notify the provider 60 days prior to conducting this audit. At that time, the provider will be notified regarding the audit's scope and criteria.

Section 1.06 Provider Compliance Audit Submission

The provider will submit the compliance audit statement to the CICP administration within 90 days of the completion of the annual financial audit or within 90 days of the close of the CICP fiscal year (June 30). The auditor should make a substantial effort to provide the completed compliance audit statement to the provider within 60 days from the date that the compliance audit was initiated.

It is the responsibility of the provider to submit the compliance audit statement to the CICP at:

Department of Health Care Policy and Financing
Colorado Indigent Care Program-Compliance Audit
1570 Grant St.
Denver, CO 80203-1818

Section 1.07 Provider Compliance Audit Extensions

Providers may seek an extension of the audit deadline by written request. The request must include a reason for the request and the date the compliance audit statement will be completed.

Section 1.08 Provider Compliance Audit Reporting Period

The audit period is for one provider fiscal year or one state fiscal year. The provider should maintain the same reporting period as previous CICP compliance audits. If the provider has a change in fiscal year or changes from calendar year to state fiscal year for the reporting period, an explanation of the change must be included with the audit compliance statement.

Section 1.09 Provider Compliance Audit Sections

The following audit guidelines represent the audit requirements and the reporting process. There are three separate components of the CICP Compliance Audit.

1. **Eligibility Audit:** This audit examines only eligibility applications completed directly by the provider. Clients serviced by the provider under the CICP but screened by another facility should not be included.

2. **Billing Audit:** This audit examines the provider's billing records and the summary information submitted to the CICP.

3. **Programmatic Audit:** This entails a general review of the internal controls the provider utilizes to comply with the program's regulations.

Section 1.10 Provider Compliance Audit Documentation Retention

The provider will keep the material associated with conducting this audit, such as audit work papers, for a period of five (5) state fiscal years following the conclusion of the audit. This material must demonstrate that the audit was performed within the standards outlined in this section. This material will not be submitted to the CICP administration unless a direct request is made.

Section 1.11 Non-Compliance

Providers that are found to be out of compliance with any of the CICP's guidelines must implement a corrective action plan. A statement from the provider's administration must be submitted to the CICP with the compliance audit statement describing the plan of correction and an implementation date. Failure to submit an action plan will result in withholding CICP payments until such a plan is received or the CICP may redirect payments to compliant providers. ***Providers are deemed out of compliance for any attribute in the Eligibility and Billing audit sections when the error rate for that specific attribute exceeds 10% of the sample.***

Section 1.12 Provider Discontinuation in CICP Participation

A provider that discontinues CICP participation must have submitted an audit for all years that the provider participated in the CICP to receive any reconciliation related payments from the CICP. Audits must be found acceptable to the CICP before final payments are released.

Section 1.13 Penalty

Failure to submit a compliance audit statement acceptable to CICP administration for any year in which a provider participates in the CICP will result in CICP billing the provider for a full refund of monies received for the period in question or withholding payments until the audit has been submitted. Failure to pay this refund will result in this issue being turned over to the State for collection. Further, CICP will not contract with such a provider until the refund is paid in full.

Section 1.14 Auditor Responsibility

The auditor is expected to understand the contents of the CICP Manual and use the CICP Manual as guidance for all audit procedures. Any disagreement between the audit procedure and the CICP Manual should be documented in the audit compliance statement. Any disagreement between the audit procedures, CICP Manual and provider policies should be resolved between the auditor and provider. If the auditor and provider cannot reach resolution, jointly and concurrently, both parties should contact the CICP administration for clarification. The auditor shall not contact the CICP administration without prior consent from the provider.

ARTICLE II. PROVIDER COMPLIANCE AUDIT REQUIREMENTS

Section 2.01 Required Areas of Eligibility Audit

Use the formatted Table 1 from Article III, Provider Compliance Audit Format, to list error rates and explanations of compliance/non-compliance for items 1-8 listed in Section 2.03.

Section 2.02 Sample Size for Eligibility Audit

1. A sample size of 25 CICP client applications completed by the provider is mandatory.

   a. If the provider completed fewer than 25 CICP client applications in the audit period, then all applications completed by the provider must be included.

   b. A provider may choose a sample size of 100 CICP applications completed by the provider to reduce the sampling error (increase the level of precision) to plus or minus 10%.

2. The sample size shall be selected independently from the Billing Audit sample, unless the sample size is so small that all client records must be used for both audit sections or the Billing Audit sample is selected using the instructions under Section 2.05(2)(a). The Eligibility Audit sample is always determined prior to the Billing Audit sample.

3. The same sample will be used for each tested attribute in the Eligibility Audit. A separate sample is not necessary for each attribute.

4. Methods used to establish the sample size and design must be stated in the compliance audit statement.

Section 2.03 The Following Items Shall be Included in the Eligibility Audit

1. Verification that an original client application is on file.

2. Verification that the "CICP Manual/Eligibility Section" guidelines were followed and that the client application sheet was completed accurately. It is not a requirement that every line on the client application be filled-out to accurately complete the client application. An error is indicated when a section or line was left blank and that omission resulted in an incorrect income determination or CICP rate assignment.

3. Verification that the correct Ability-to-Pay scale was used and that the correct CICP rate was calculated.

4. Verification that the applications were dated.

5. Verification that the applications were signed.

6. Verification that the client was not eligible for Medicaid or CHP+. The provider must have all potentially eligible clients apply for Medicaid or CHP+ unless the client would not be eligible due to categorical restrictions. The reason(s) for not directing a potentially eligible client to apply for Medicaid or CHP+ must be documented or noted by checking the appropriate check box on the CICP client application (effective with the FY 2006 client application). Clients who are potentially eligible for Medicaid or CHP+ will need to have a denial letter from the appropriate program to accurately complete the CICP client application.

7. Verification that the income and extraordinary expense documentation for the application is maintained on file.

    a. There must be documentation that the provider made a reasonable effort in requesting and obtaining documentation of financial resources for the client. Different situations may require different documentation. In some circumstances, no documentation may be available (e.g., if the client is a migrant worker, homeless, or transient). In such instances, the provider must state in the remarks section, or on an attached page, why income was calculated without supporting documentation.

    b. Copy of one month's paycheck stub will suffice as income documentation.

    c. Documentation must be maintained in the provider's records for cases where a client rating was not completed or where the client was assigned a rating different from that requested because of the patient's lack of cooperation or inability to supply the needed financial data.

8. In cases for which the provider has changed a client's rating to a lower rate through the use of Management Exception (see Eligibility Section), written documentation must exist to justify the change. The auditor must also state how many management exceptions were found in the sample, as well as the percentage of total ratings such exceptions represent.

Section 2.04 Required Areas of Billing Audit

Use the formatted Table 2 from Article III, Provider Compliance Audit Format, to list error rates and explanations of non-compliance for items 1-6 listed in Section 2.06.

Section 2.05 Sample Size for Billing Audit

1. A sample size of 25 CICP unique clients for which the facility submitted billing records to the CICP is mandatory.

    a. If the provider submitted fewer than 25 CICP client billing records to the CICP in the audit period, then all client billing records must be included.

b. A provider may choose a sample size of 100 CICP client billing records to reduce the sampling error (increase the level of precision) to plus or minus 10%.

2. In collaboration with the auditor, the provider shall decide which of the following methods to utilize in determining the sample size for the Billing Audit:

   a. The sample size shall be selected independently from the Eligibility Audit sample, unless the sample size is so small that all client records must be used for both audit sections.

   b. The sample size shall be selected directly from the Eligibility Audit sample, such that a random billing record will be selected for each client application selected under the random sample in the Eligibility Audit. The Eligibility Audit sample is always determined prior to the Billing Audit sample.

3. The sample selected must include billing records for patients who have third party insurance coverage for part of their medical services, in the proportion they represent CICP patients.

4. The sample will be used for each tested attribute in the Billing Audit. A separate sample is not necessary for each attribute.

5. Methods used to establish the sample size and design must be stated in the compliance audit statement.

Section 2.06 The Following Items Shall be Included in the Billing Audit

1. Verification that billing records are available within the facility's billing system or other archive.

2. Verification that the client was eligible for CICP. Documentation could include a copy of the CICP application or copy of the client's CICP card.

3. If applicable, verification that reimbursement was sought from a third party associated with the billing record.

4. Verification that the patient was charged the correct copayment.

5. Verification that the billing record was translated correctly from the provider's billing system to the billing information submitted to the CICP:

   a. Verification that the billed charge was included in the total charge reported to the CICP.

   b. Verification that any reimbursement due from a third party associated with the charge was included in the third party liability figure reported to the CICP.

c. Verification that any client copayment associated with the charge was included in the client liability figure reported to the CICP.

6. Verification that the total charge for the service was the same charge billed to non-CICP patients during the same period.

Section 2.07 Required Areas of the Programmatic Audit

The following items do not have an error rate associated with the test. The provider is either compliant or noncompliant with the attribute. Using the formatted Table 3 from Article III, Provider Compliance Audit Format, state if the provider was compliant or noncompliant, and provide an explanation, for items 1-9 listed below.

Section 2.08 The following items shall be included in the Programmatic Audit

1. Verification that the provider has maintained the client eligibility applications and associated documents for a period of five state fiscal years as required by the contract between the CICP and the facility. No sampling is necessary to satisfy this requirement. This is a general review of the internal controls and procedures for maintaining these records. See Section 1.04, Records Retention and Availability.

2. Verification that the provider has maintained the client billing records and associated documents for a period of five state fiscal years as required by the contract between the CICP and the facility. No sampling is necessary to satisfy this requirement. This is a general review of the internal controls and procedures for maintaining these records. See Section 1.04, Records Retention and Availability.

3. Verification that the provider's detail client billing records support the summary billing information submitted to the CICP, as explained in the CICP billing manual. If the provider has physician participation in the CICP, detail client billing records must exist to support the information submitted to the CICP. The auditor shall verify that detail client billing records exist to support all summary information submitted to the CICP. This is not meant to be an all-encompassing review of every billing record and the auditor determines the tests on which to render a statement or opinion. This requirement is intended to include verification or testing of billing records for the current audit period only, not for the period of five state fiscal years as required above.

4. Verification that the provider complied with legislated medical service priorities. This means that, at minimum, emergency medical care was provided to all medically indigent patients for the full contract year. The second priority is to provide any additional medical care that is a serious threat to the health of the medically indigent. The third priority is providing any other additional medical care. This requirement is intended to include verification or testing for the current audit period only, not for the five state fiscal years required above.

5. Review of utilization review activities in general to ensure that indigent patients were included in the sample receiving utilization review. (The auditor is not responsible for conducting a utilization review or for reviewing any individual patient's medical records.) This requirement is intended to include verification or testing for the current audit period only, not for the five state fiscal years as required above.

6. Review of the patient appeals process to ensure that appeal guidelines and patient notifications, as defined in the CICP manual, are fulfilled. This requirement is intended to include verification or testing for the current audit period only, not for the five state fiscal years as required above.

7. Review of the provider's internal controls. The audit compliance statement needs to indicate that a review of internal controls was conducted. Any weaknesses in internal controls must be reported in the audit compliance statement. This requirement is intended to include verification or testing for the current audit period only, not for the five state fiscal years as required above.

8. Hospital Providers Only: If the provider has physician participation in the CICP, verification that fully executed contracts exist between the provider facility and the physician/physician group. This requirement is for hospitals only and is intended to include verification or testing for the current audit period only, not for the five state fiscal years as required above.

9. Hospital Providers Only: Verification that the provider accurately submitted data on the "MEDICAID ELIGIBLE PATIENT DAYS SURVEY for CALENDAR YEAR 2003 DATA." This requirement is intended to include verification or testing records for this specific survey only.

10. Public-Owned Hospital Providers Only: Verification that the provider accurately submitted the "Certification of Public Expenditure Letter" for state fiscal year 2005. This requirement is intended to include verification or testing records for this specific letter only.

    The following providers are considered public-owned hospitals for this attribute: Denver Health Medical Center, University Hospital, Arkansas Valley Regional Medical Center, Aspen Valley Hospital, Delta County Memorial Hospital, East Morgan County Hospital, Estes Park Medical Center, Gunnison Valley Hospital, Heart of the Rockies Regional Medical Center, Huerfano Medical Center, Kit Carson County Memorial Hospital, Melissa Memorial Hospital, Memorial Hospital, Montrose Memorial Hospital, North Colorado Medical Center, Poudre Valley Hospital, Prowers Medical Center, Sedgwick County Memorial Hospital, Southeast Colorado Hospital and LTC, Southwest Memorial Hospital, St. Vincent General Hospital District, The Memorial Hospital, Wray Community District Hospital, Yuma District Hospital

11. The Auditor should document any disagreement between the audit procedure and the CICP Manual. This attribute is available for the auditor to request clarification in future additions of the CICP Manual.

Section 2.09 General Information Requirement

Compliance statements must contain the following:

1. Name of auditor(s) or auditing firm.
2. Address of auditor(s) or auditing firm.
3. Starting and ending dates of the audited period.
4. Starting and ending dates for the audit.
5. The name of the audited provider.
6. The name of the contact person at audited provider.

It is the responsibility of the provider to submit the audit compliance statement to the CICP at:

Department of Health Care Policy and Financing
Colorado Indigent Care Program-Compliance Audit
1570 Grant St.
Denver, CO 80203-1818

ARTICLE III. PROVIDER COMPLIANCE AUDIT FORMAT

The following format shall be used for reporting the audit results. This general template can be modified by the Auditor, but the required information cannot change.

General Information Requirement

1. Name of auditor(s) or auditing firm:_____
2. Address if auditor(s) or auditing firm:_____
3. Starting and ending dates of the audited period:_____
4. Starting and ending dates for the audit:_____
5. The name of the audited provider:_____
6. The name of the contact person at audited provider:_____

Eligibility Audit

Explanation of how Eligibility Audit sample size was established: _____

_____

_____

_____

_____

Table 1: Required Areas of Eligibility Audit

Attribute	Sample Size	Errors Noted	Error Percent	Compliance* (Yes/No)
1 Application on File				
2 Manual Used Correctly				
3 Correct CICP Rating				
4 Application Dated				
5 Application Signed				
6 Not eligible for Medicaid or CHP+				
7 Documentation				
8 Management Exception				

*The attribute is out of compliance if the error rate exceeds 10% for the specific attribute tested.

Explanation of Compliance/Non-Compliance for Eligibility Audit

Attribute 1:_____

_____

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Attribute 2:_____

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Attribute 3:

Attribute 4:

Attribute 5:

Attribute 6:

Attribute 7:

Attribute 8:

Billing Audit

Explanation of how Billing Audit sample size was established: _____

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Table 2: Required Areas of Billing Audit

Attribute	Sample Size	Errors Noted	Error Percent	Compliance* (Yes/No)
1 Billing Record Available				
2 Client Eligible				
3 Third Party				
4 Correct Copay				
5a Translated – Total Charge				
5b Translated – Third Party				
5c Translated – Copay				
6 Same Charge				

*The attribute is out of compliance if the error rate exceeds 10% for the specific attribute tested.

Explanation of Compliance/Non-Compliance for Billing Audit

Attribute 1:_____

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Attribute 2:_____

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Attribute 3:_____

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Attribute 4:

Attribute 5a:

Attribute 5b:

Attribute 5c:

Attribute 6:

Programmatic Audit

Table 3: Required Areas of Programmatic Audit

Attribute	Compliance* (Yes/No)
1 Client Applications	
2 Billing Records	
3 Reporting	
4 Legislative Priorities	
5 Utilization Review	
6 Client Appeals	
7 Internal Controls	
8 Physician Contracts	
9 Medicaid Survey	
10 Certification Letter	

*The attribute is out of compliance if the auditor finds significant evidence that the specific attribute was not fulfilled.

Explanation of Compliance/Non-Compliance for Programmatic Audit

Attribute 1:_____

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Attribute 2:_____

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Attribute 3:_____

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_____

Attribute 4:

Attribute 5:

Attribute 6:

Attribute 7:

Attribute 8:

Attribute 9:

Attribute 10:

Attribute 11:

ARTICLE IV. NON-COMPLIANCE

Section 4.01 Eligibility and Billing Audit Sections

Providers are deemed out of compliance for the Eligibility and Billing audit sections when any of the attributes has an error rate that exceeds 10%.

Section 4.02 Programmatic Audit Section

Providers are deemed out of compliance with the Programmatic audit section if the auditor finds significant evidence that the attribute was not fulfilled.

Section 4.03 Corrective Action Plan Requirement

Providers that are out of compliance with any of the CICP's audit attributes must submit and implement a corrective action plan.

1. A corrective action plan must be submitted to the CICP by the provider's administration with the provider's compliance audit statement.

2. A corrective action plan must describe how each attribute found out of compliance will be corrected and include an implementation date.

3. Providers shall not state that the level of sampling error of 20% was too high as a reason for non-compliance. If a provider feels that the sampling error of 20% misrepresents their actual population, then the provider should use a sampling error of only 10%. This requires increasing the sample size to 100 from 25 on all attributes in the Eligibility and Billing sections of the audit.

4. Failure to submit a suitable action plan will result in withholding CICP payments until such a plan is received.

5. Send the Provider Compliance Audit Statement & Corrective Action Plan to:

Department of Health Care Policy and Financing
Colorado Indigent Care Program-Compliance Audit
1570 Grant St.
Denver, CO 80203-1818